

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-050084

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

12205

FILED DEC 20 1963

VS 300
Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK

OR
TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		c. STATE Missouri b. COUNTY	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL		d. STREET ADDRESS (If outside, give location) 4712a Ashland	
3. NAME OF DECEASED (Type or print) ALVIN E. WHITE		4. DATE OF DEATH December 8 1963	
5. SEX Male	6. COLOR OR RACE Negro	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 8-11-15
9. AGE (last birthday) 48	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur	11. BIRTHPLACE (City and state or country) Ozan, Arkansas	12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME Steve White		13b. MOTHER'S MAIDEN NAME Ella Suttles	
14. NAME OF HUSBAND OR WIFE Mildred White		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of)	
16. SOCIAL SECURITY NO. no		17. INFORMANT Guarante Palmer	
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary emboli Vicious adenoma sigmoid colon DUE TO (b) 211X DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Acute 8 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
21. I attended the deceased from 11/23/63 to 12/8/63 and last saw him alive on 12/8/63		Death occurred at 11:30 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) FRANK R. BRADLEY, M.D.		22b. ADDRESS BARNES HOSPITAL	
22c. DATE SIGNED 12/9/63		23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	
23b. DATE 12-10-63		23c. NAME OF CEMETERY OR CREMATORY Booker Washinbton	
23d. LOCATION (City, town, or county) E. St. Louis, Illinois		24. FUNERAL DIRECTOR NASH FUNERAL HOME	
25. DATE RECD. BY LOCAL REG. DEC 10 1963		26. REGISTRAR'S SIGNATURE Earl Smith, M.D.	

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *By James Nash*

Licensed Embalmer No. 4434

P. O. Address 111 27 13 56

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.